outside by the procedure which is contemplated in this Bill."[5] Lord Horder, who in essence said last week what he said so well in 1936, observed "that the good doctor is aware of the distinction between prolonging life and prolonging the act of dying." He viewed with misgiving the "suggested intervention of the bureau as replacing that complete confidence and understanding which is one of the most satisfactory of all human relationships." In last week's debate Lord Horder emphasized again that this matter of euthanasia was not really one for the doctor to settle, but that as a doctor he hoped he could give some guidance to those discussing such a settlement; and he made a statement which has special relevance at a time when so many advances are being made in therapeutics. "As to incurability of a disease in general, incurability is the measure at the moment of the doctor's experience of incurability, and those who have the most experience use the term incurability least often, because in Medicine we talk more and more of controlling disease rather than of curing it."[6] Lord Uvedale stressed the possibility of error in diagnosis and saw the practice of euthanasia as something that would disrupt the bond of sympathy and affection existing between the doctor and the patient in a late stage of a disease. Three other medical Peers —Lord Webb-Johnson, Lord Haden-Guest, and Lord Amulree—put the weight of their experience in the same scales against legislation on the practice under discussion.

The subject of euthanasia is one that is bound to stir up emotion and prejudice. It is not something that can be decided by controlled experiment, nor would the legalization of voluntary euthanasia be likely to show an effect on the suicide rate. When the World Medical Association met in New York in October of this year doctors from different parts of the world declared themselves to be in a majority against the introduction of such a practice into Medicine. While it is true that it will be the community at large that has the decision in its hands, the doctors who would have to execute the community's wishes in this matter must have a say out of proportion to their numbers. No one can fail to be impressed by the fact that men of great responsibility in the medical and other learned professions firmly believe that such a measure as voluntary euthanasia should be introduced as a benefit not to be withheld from the man or woman dying from a painful and incurable disease. Yet in the two debates in the House of Lords medical men of the highest eminence and unrivalled experience have given cogent expression to what surely must be the medical man's instinctive attitude. When faced with disease and injury the doctor's job [illegible] on all methods of [illegible] e patient to bring disease under control. And so little is yet firmly known of the natural history of disease, especially perhaps of cancer, that the pressure on the doctor by patient and relative to seek a way out by euthanasia would introduce a new and disturbing element in the doctor's assessment of a case. Those many medical men who are opposed to legislation on this subject will see much point in the observation made by the Earl of Iddesleigh when he said: "There is something very terrible about this reversal in the morale of the sick-room." A part of the morale of the sick-room in which a person lies dying resides surely in the general belief that the good doctor will distinguish between prolongation of life and the unnecessary prolongation of the act of dying.

CHLORAMPHENICOL NOW AVAILABLE

We print on page 1326 a Ministry of Health statement that from December 11 chloramphenicol will be generally available on prescription. This drug is one of three new antibiotics which have been developed in the United States, and all of them are available without restriction in that country. Owing to shortage of dollars they cannot be made so in Great Britain until manufactured here. The production of chloramphenicol, which is the synthetic form of "chloromycetin," has been undertaken in England with commendable energy, and supplies are now adequate for its release. Plans for the home production of "aureomycin" and "terramycin" are unlikely to mature for some time. Fortunately the indications for all three antibiotics are broadly the same, though there are a few absolute exceptions to this rule and a number of differences in relative efficacy for particular infections. In the Ministry of Health statement of indications for chloramphenicol the expression, "More effective than any of the therapeutic agents at present generally available," presumably refers only to the present position in this country. It is doubtful whether the action of the drug even equals that of aureomycin in primary atypical pneumonia. If experimental infection with this virus in cotton rats is any guide to its behaviour in man, then, according to the findings of Eaton,[1] aureomycin is much the more effective of the two.

An outstanding merit of chloramphenicol is its action in typhoid fever, which naturally comes first on the list of unqualified indications. On the other hand, treatment with the drug does not prevent the persistence of a

[1] *Proc. Soc. exp. Biol., N.Y.*, 1950, **73**, 24.
[2] *Amer. J. trop. Med.*, 1950, **30**, 357.
[3] Quoted by Kirby, W. M. M., *J. Amer. med. Ass.*, 1950, **144**, 233.
[4] Ross, S., *et al.*, *New Engl. J. Med.*, 1950, **242**, 173.
[5] *J. clin. Invest.*, 1949, **28**, 953.
[6] *New Engl. J. Med.*, 1950, **242**, 119.
[7] *Sth. med. J. Bgham, Ala*, 1950, **43**, 85.
[8] See annotation in *British Medical Journal*, 1950, **1**, 829.

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carrier state, nor is it of the slightest value in trying to abolish this. Smadel,[2] in a review of the pioneer work on the treatment of typhoid and typhus in which he himself played so large a part, proposes an explanation for this anomaly. The action of chloramphenicol—and indeed of all three newer antibiotics—unlike that of penicillin and streptomycin, is simply to inhibit bacterial growth: organisms are not actually killed even when exposed to high concentrations. It is thus easy to picture the survival of bacilli despite treatment which is fully effective in terminating the disease. According to Rammelkamp[3] the same thing happens when aureomycin is given for haemolytic streptococcal throat infections, for, though the clinical results equal those obtainable with penicillin, the organism is not eliminated. Chloramphenicol is also indicated for salmonella enteritis. But here again a carrier state is apt to persist: it did so in seven out of nine such cases carefully studied at the Children's Hospital, Washington.[4] Among other intestinal infections, only ulcerative colitis is mentioned in the Ministry's statement—as a disease not to be treated with chloramphenicol. There is no mention of infantile gastro-enteritis or of dysentery.

Other unquestionable indications for chloramphenicol —undulant fever, rickettsial infections, psittacosis, and lymphogranuloma inguinale—are all rare conditions. It has been obtainable for these purposes for some time past, and the new uses to which it will now be put, such as the treatment of urinary and respiratory-tract infections generally, are of a less specific nature and call for some discrimination. To direct such treatment intelligently will also require help from the laboratory. It is as well that this is pointed out in the Ministry's statement where urinary-tract infections are listed, particularly since two of the causal organisms mentioned are often resistant to the drug. Although it is excreted in high concentration in the urine much of it is in a combined and consequently inactive form, and sensitivity of the organism to 25 μg. per ml. is a minimum requirement if treatment is to have any prospect of success. Of 19 strains of *Ps. pyocyanea* tested by McLean and his colleagues[5] only six were inhibited by this concentration or less, the remainder being more resistant. Hewitt and Williams[6] and Garvey and his colleagues[7] report respectively 93 and 21 cases of urinary-tract infections treated with chloramphenicol, and in both papers unsatisfactory results are recorded in infections due to *Ps. pyocyanea* and, to a less extent, *Proteus*. *Bact. coli* and *Bact. aerogenes*, on the other hand, were found sensitive both *in vitro* and *in vivo*.

It is to be hoped that the drug will not be used indiscriminately for urinary-tract infections. Laboratory evidence of its potential efficacy should be obtained first, and the same is true of multiple infections elsewhere, particularly in the air passages. As a general rule chloramphenicol is more effective than aureomycin for Gram-negative infections, whereas the reverse holds for Gram-positive infections. Thus, as the statement says, the drug indicated for penicillin-resistant staphylococcal infection is aureomycin. In so far as this applies also to pneumococci and streptococci generally—and the indications are that it does—chloramphenicol cannot be expected to give results as good as those obtainable with aureomycin in miscellaneous infections in which such organisms are concerned. There will doubtless be a strong temptation to try chloramphenicol when penicillin has failed in fever of unascertained cause, but this sort of blind therapy is to be deplored until every possible diagnostic aid has been exhausted. Even should fever abate during treatment the diagnosis is still unmade, and there is no knowing how long the drug should be continued. It will be most unfortunate if chloramphenicol comes to be regarded by the public as the latest wonder drug, and to be demanded by patients themselves because they have read sensational accounts of its powers. There is no appeal for economy in the Ministry of Health's statement, but it should perhaps be known that the drug is expensive: adequate treatment costs at least a pound a day.

Chloramphenicol is taken by mouth. Since excretion is comparatively slow, four doses a day are enough. The total daily dose used has been 4 g. or even more in severe infections and sometimes less in less serious conditions. No serious toxic effects have been reported except the occasional occurrence of granulocytopenia. Vascular collapse occurring during the treatment of typhoid fever with chloramphenicol has been attributed to the rapid liberation of potent endotoxins.[8] Minor unpleasant effects are anorexia and dryness of the mouth. Administration to children who cannot swallow capsules presents difficulty, since the drug is exceedingly bitter.

PROFESSOR E. D. ADRIAN, P.R.S.

Since the Royal Society was founded in 1662, eight of the 48 presidents have been medical men, the last being Sir Henry Dale, who was elected president 10 years ago. The medical profession is proud that once again one of its distinguished members has been elected to this, the highest, office in British science, and will extend its warmest congratulations to Professor E. D. Adrian, who was elected P.R.S. on November 30.

Adrian has been professor of physiology at Cambridge since 1937, when he succeeded Joseph Barcroft. World-wide recognition was given to his work when in 1932 he shared with Sir Charles Sherrington the Nobel Prize in

[1] Article signed A. V. H. in *St Bart's Hosp. J.*, April, 1937.

physiology and medicine, and in 1942 he became one of those select few to join the Order of Merit. Among his many other distinctions was the award of the Gold Medal of the Royal Society in 1934 and of its Copley Medal in 1946. Adrian, who was a King's scholar at Westminster School, showed that this was not necessarily a bad introduction to science when he achieved what is believed to be a record of obtaining first-class honours in five separate subjects in the Natural Science Tripos at Cambridge.[1] After an interlude at St. Bartholomew's Hospital and the Hospital for Nervous Diseases at Queen's Square, Adrian returned to Trinity College as a Fellow in 1913. There he began with Keith Lucas his investigations into the fundamental nature of the activity of the nerve cell, which made his laboratory a centre of research in electro-physiology. During the war of 1914–18 Adrian and Keith Lucas were looking into the possibility of using the thermionic valve for the detailed investigation of the electrical activity which is associated with nervous action. After Lucas's death in 1917, while flying, Adrian carried on those researches which have so vividly illuminated the nature of nervous activity. It was not until he had reinvestigated the discoveries of Berger that all the implications of changes in brain potentials were fully and widely appreciated, which led, among other things, to the clinical use of the electroencephalogram.

Adrian inherited and enriched the Cambridge tradition of manual dexterity and subtlety in experiment. His lectures to Cambridge students on the physiology of the nervous system were enlivened by constant reference to clinical neurology, reflecting his experience in this specialty during the 1914–18 war. Professor A. V. Hill,[1] writing in 1937, summed up Adrian's work thus: "To have given a new quantitative basis to nervous behaviour, to have shown that afferent or efferent effect in any given neurone depends on the pattern in time of the impulses which travel in it, is the great achievement of Adrian's recent work. In it he and his pupils have explored the activity of the single neurone, the single sensory end-organ, the single muscle group, their excitation, their adaptation, their fatigue." By his work on the basis of sensation and on the nature of nervous activity, Adrian has broken down still one more barrier which lies between man and the knowledge of his own nature.

TUBERCULOSIS AS A PRESCRIBED DISEASE

Dr. Edith Summerskill, Minister of National Insurance, stated in Parliament last week that she has accepted the recommendation of the Industrial Injuries Advisory Council that tuberculosis should be a "prescribed" disease. Section 55 of the National Insurance (Industrial Injuries) Act, 1946, lays it down that "a disease or injury may be prescribed . . . in relation to any insured persons if the Minister is satisfied that (*a*) it ought to be treated, having regard to its causes and incidence and any other relevant considerations, as a risk of their occupations and not as a risk common to all persons; and (*b*) it is such that in the absence of special circumstances the attribution of particular cases to the nature of the employment can be established or presumed with reasonable certainty." When the Industrial Diseases Subcommittee of the Industrial Injuries Advisory Council was asked to consider and advise on the question whether tuberculosis (and other communicable diseases) should be prescribed as an industrial disease of nurses and other health workers it was set a very difficult task. However, in spite of the difficulties the council has succeeded in bringing out a concise and informative report[1] with a number of cut-and-dried recommendations on which the Minister has already acted. It is doubtful if any will disagree with the general recommendations that diseases due to tuberculous infection might properly be prescribed under the Act in so far as they affect persons "having close and frequent contact with the infection by reason of their employment." The conditions under which the disease may be presumed to be due to the nature of the employment are clearly laid down. But the council was quite definite in stating that the attribution of particular cases of the disease to the nature of the employment could not be established, as distinct from presumed, with reasonable certainty except on rare occasions. In reaching decisions of such importance the council was helped by the evidence put before it by many expert witnesses. Earlier this year the Council of the B.M.A. approved a memorandum[2] on this subject prepared by a committee under the chairmanship of Dr. R. R. Trail, and this memorandum was formally submitted to the Industrial Diseases Subcommittee of the Industrial Injuries Advisory Council. The recommendations of the latter body are in close agreement with those of the B.M.A. committee.

It is of course to be expected that some of the points of detail in this report will give rise to controversy. In fact there will be many who will agree with the interesting and practical note by Mr. T. A. E. Layborn, dissenting from a recommendation of the council that the disease may be presumed to have been contracted at work for as long as two years after employment ceased. He also considers that there should be a definite minimum qualifying period of six months' employment (the council's recommendation is six weeks) before the presumption is permitted that the infection was a result of previous employment. No doubt some will question the council's view that it is impracticable at present to insist that claimants under the Act should have had a pre-employment tuberculin test. Other problems which the council had to face were the definition of tuberculosis and what is meant by "close and frequent contact." Those who consider that the primary infection is all-important and that subsequent disease is due to endogenous exacerbation will support Mr. Layborn's comment that "circumstances quite unconnected with nursing and

[1] *Tuberculosis and Other Communicable Diseases in Relation to Nurses and Other Health Workers*, Ministry of National Insurance, 1950.
[2] *British Medical Journal*, 1950, **1**, 484.

other health work are responsible for the great majority of cases of the disease," and they may feel that the council has not given sufficient weight to this view. Nevertheless the wisdom of the report outweighs these debatable details, and it will bring much satisfaction to all tuberculosis workers. Though industrial injury benefits are higher than those for ordinary sickness under the National Insurance Act, there is some uncertainty about the effect of "prescribing" tuberculosis on nursing recruitment. Some potential entrants to the profession may now have a greater sense of security, while others may be put off by the possible danger. The council has shown good judgment in refusing to recommend "block" prescription of other communicable diseases. It appreciates that the recommendations about tuberculosis will have wide repercussions, and it prefers to await developments before extending the concessions.

EMOTIONS AND THE SKIN

Clinical reports on the association between urticarial rashes and emotional changes have been quite frequent since 1935. A recent report by Graham and Wolf[1] is interesting, because clinical examination was combined with experimental investigation. The subjects were 17 women and 13 men who had had repeated attacks of urticaria, showing either as superficial weals or deeper and more diffuse swellings. Some had an itching blotchy erythema with pronounced dermographism. A fairly complete life history was obtained from each patient, with particular attention to exposure to possible antigens and the emotional aspect of situations in which attacks of urticaria were known to have occurred. The patients were then asked to discuss these situations, while observations were made on skin temperature and the reactive hyperaemia threshold. To carry out the latter test a weight is applied to the skin long enough to cause a zone of erythema (due to dilatation of the minute vessels) to appear after removal of the weight, the time being measured. This is a test of the tonus of the vessels and not of their calibre. Skin temperature, on the other hand, is dependent on the dilatation or constriction of the arterioles. Room temperature was kept constant throughout the experiments. In a number of cases the authors also tested the sensitivity of the skin to pilocarpine and histamine introduced electrically by iontophoresis. In 29 out of the 30 cases there was an invariable relation between past attacks of urticaria and the emotional state at the time. Curiously, there was no important association with foods or other antigens. The nature of the emotional state was also specific. Emotions of anxiety, hostility, grief, or dejection were not directly associated with attacks of urticaria, but the prominent emotional state was one which might be called resentful frustration. At the time when the attack happened the patients had felt themselves "on the spot" in some way and unable to do anything about it. The authors' experiments confirmed this impression. They recorded the emotional state on graphs—through self-consciousness, anxiety, tears, and dejection to resentment—as the patient discussed his preoccupations in the course of the interview; and, whereas other emotions caused little change, when resentment was felt the skin temperature rose, the tonus of minute vessels fell, and the patient might even start to scratch. Other emotions were not entirely without effect; anxiety tended to cause an increase in minute vessel tone and delay of flushing after pressure, and dejection was associated with a fall in minute vessel tone and also a fall in skin temperature, probably due to arteriolar constriction.

The authors make an interesting point when they say that, while they were able to establish a relation between urticaria and a particular mental state, they were often unable to understand just why the patient had taken that emotional attitude. Often enough when the patient explained that "there was nothing I could do," it seemed to the observer that, in fact, a good many things could have been done. The patients, as a whole, not only failed to express hostility but tended not even to feel it. In the past they had adopted rather a passive attitude to punishment from parents or superiors. Some of the women found hostility unacceptable in terms of their standards of proper behaviour. An attack of urticaria sometimes occurred while a patient was pondering on his problems, but at such times there was an absence of aggressive fantasies. On the other hand there was no general lack of initiative and energy of character; the passivity was shown only in meeting external hostility. Physiologically urticaria is due to an increased tendency to vascular dilatation both in the arterioles and in the minute vessels. Graham and Wolf do not find it necessary to postulate the local liberation of histamine. The permeability of the vessels increases as they dilate, until the point is reached where exudation occurs. Local stimulation—for instance, the rubbing of a collar—may decide the actual place of appearance.

To a certain extent these experiments run counter to prevailing clinical opinion, which would ascribe an important role to the emotion of hostility in provoking urticaria. It is in any case a little difficult to distinguish between hostility and resentment. Nevertheless it is investigations of this kind that aid in the exploration of psychosomatic relationships. Elsewhere in this issue we publish a report by Drs. H. J. Shorvon, A. J. Rook, and D. S. Wilkinson on the treatment of skin disorders by inducing emotional release through "drug abreaction." Much has yet to be learned about the indications for this treatment, but the fact that such encouraging results have already been obtained not only confirms the importance of psychological factors in precipitating certain skin disorders but shows that psychiatric treatment is far from impracticable. An interesting finding was that after abreaction some patients were able to reduce to reasonable proportions symptoms which had come to assume an overwhelming significance for them. Increasing knowledge of the pathogenesis of such obscure conditions as the neurodermatoses should help in another direction. One of the greatest weaknesses of psychiatric observations is that they have to be expressed so largely in ill-defined qualitative words and phrases. If we could redefine such psychological expressions as "anxiety" and "depression" in physiological terms and begin to measure differences between patients and in the same patients at different times it would go far to clear away present obscurities.

[1] *J. Amer. med. Ass.*, 1950, **143**, 1396.

very little must be applied and the new ointment should be put on the top of the old. No other dressing is necessary. A mild "sphagnol" ointment often proves helpful, and *x*-ray treatment is invaluable in old-standing cases. If injections are indicated these may be carried out during the treatment of the eczema.

Severe Cases.—When the eczema is extensive or severe, treatment should be on the above lines, but combined with a period of absolute rest in bed, with the lower end of the bed elevated. In many cases there are indications for operation. This can be carried out under penicillin cover after rest and local treatment have controlled the eczema.

FIG. 3.—Chronic varicose ulceration with scarring, pigmentation, and eczema.

Varicose Ulceration

There are many methods of treatment of varicose ulceration. I have gradually come to the conclusion that long-standing cases are best treated by operation if sound healing of the ulceration and a useful limb requiring no external support are to be secured. The special indications for operation are either incompetent veins in the thigh, incompetent communicating veins in the calf, or incompetent thick-walled veins.

Cases Suitable for Injection.—If the veins are of a type suitable for injection, then treatment must be built around this, and small and early ulcers may be cured by this measure alone. Most cases, however, require a combination of injections and external support. Injections should start distally and as near the ulcerated area as is safe, and the limb should be enclosed in elastoplast below the knee. This should be changed weekly and a further injection given. Elastoplast treatment should be continued for about three weeks after the ulceration has healed and it should be followed by the use of a crêpe bandage for a further three to four weeks.

Cases Suitable for Operation.—The ulceration is healed by postural treatment before carrying out surgery. This involves a period of absolute rest in bed, with the lower end of the bed raised on 8-in. (20-cm.) blocks. The ulcerated area should be dressed with an ointment of equal parts of zinc oxide ointment and soft paraffin, and covered with light gauze dressing. Fresh ointment is applied daily after cleaning off the old ointment with liquid paraffin. The oedema and pain rapidly clear up, and a foul infected ulcer is converted to a clean granulating wound which heals steadily. Penicillin cover has made operation possible immediately healing has occurred. This method of treatment may also be used as a preliminary to injections or permanent supports.

The various types of adhesive dressings cannot be considered, nor can the treatment of very complicated cases be discussed in which there is ulceration, eczema, chronic phlebitis, and bone change. There are two points which may be of some value to the general practitioner. The first is that, although penicillin applications may sterilize an ulcer, they will not necessarily lead to healing, and may, exceptionally, cause a generalized skin eruption. Secondly, rashes may follow the prolonged use of ointments containing sulphonamides.

Haemorrhage

External haemorrhage may arise either spontaneously from thin-walled and congested malleolar varicosities, or it may result from injury. In either case the blood loss may be rapid and considerable. Immediate elevation of the limb must be followed by a firm local dressing. Ulceration may develop at the site of the haemorrhage. Subsequent treatment of the veins is indicated.

Internal haemorrhage may occur. Spontaneous cases result from the rupture of minute subcutaneous vessels, and active treatment is rarely needed. Traumatic haemorrhage may occur when a large vein is torn but the skin remains intact. A small haematoma may resolve satisfactorily with elastoplast treatment, but a large one may require evacuation. Traumatic thrombosis may lead to an extending phlebitis.

Pregnancy

Varicosities usually start about the second or third month of pregnancy. Rapid progress often occurs when there is a bad family history of varicose diseases, and especially when varicosities have started at puberty. Uncomplicated varicosities do not cause oedema, but may be associated with other causes of swelling of the lower limbs. The degree of discomfort produced is partly an individual factor and partly related to the speed of development of the varicosities. Generalized skin congestion and discoloration may be marked. Vulval varicosities and piles may also develop.

Active treatment is not often advisable, because success is unlikely owing to the speed of development of the condition. If local symptoms are marked or if the veins are large, then crêpe bandages or elastic stockings should be worn and an afternoon rest taken if possible. Injection treatment should be regarded as quite exceptional, and quinine should not be used. The veins usually show considerable improvement after delivery, but they never return to the condition they were in before the pregnancy. After the baby has been weaned active treatment should be carried out in keeping with the general principles already indicated. Every subsequent pregnancy tends to aggravate existing varicose veins, and thus increases the risks of subsequent complications. If active treatment has been carried out and a further pregnancy is desired, then such treatment should be completed well before the pregnancy starts, and should be safeguarded by wearing a below-knee stocking throughout the pregnancy.

In a leading article in the *Journal of the American Medical Association* (September 9, 1950, p. 182) it is estimated that the minimum cost to medical students of attending medical school for one academic year, including the cost of tuition, other fees, books, equipment, all essential living, and travel, ranges from $567 (£202 at the present rate of exchange) to $2,252 (£804), with a median of $1,473 (£526).

Walter Stoneman, London.]

PROFESSOR E. D. ADRIAN, O.M., M.D., F.R.C.P., P.R.S.

Professor E. D. Adrian, who in 1937 succeeded the late Sir Joseph Barcroft in the chair of physiology at Cambridge, was elected President of the Royal Society on November 30, being the ninth medical man to occupy this position (see also leading article at p. 1320).

DISTRIBUTION OF CHLORAMPHENICOL (CHLOROMYCETIN)

From December 11 all doctors will be able to prescribe chloramphenicol ("chloromycetin") for their private or N.H.S. patients. The Ministry of Health has issued the following statement (see leading article on p. 1319):

Owing to improvement in supplies, chloramphenicol (chloromycetin) will be generally available on prescription from December 11. The following provisional lists are intended as a guide to practitioners in prescribing this antibiotic.

There are certain infections (list 1 below) in the treatment of which chloramphenicol is more effective than any of the therapeutic agents at present generally available. Apart from these there is a variety of infective conditions (list 2 below) in which the value of treatment is less certain; preliminary trials both in this country and abroad have given variable results, and further experience is needed before chloramphenicol can be recommended as routine treatment in these diseases. In certain diseases (list 3 below) there is no satisfactory evidence that chloramphenicol has any therapeutic value.

1. *Infections in which the Therapeutic Value of Chloramphenicol is Superior to that of Sulphonamides or Penicillin.*—Typhoid and paratyphoid fevers (excepting carriers), brucellosis (undulant fever); rickettsial diseases—i.e., typhus, scrub typhus, Q fever; psittacosis; lymphogranuloma inguinale; atypical (virus) pneumonias; urinary tract infections resistant to sulphonamides and penicillin (these include infections due to resistant strains of *B. coli, B. proteus, Ps. pyocyanea,* and *Str. faecalis.* Sensitivity of the organism to chloramphenicol should be determined).

2. *Infections in which Therapeutic Benefit from Chloramphenicol has been Reported but not Fully Substantiated.*—Whooping-cough, salmonella food-poisoning, *H. influenzae* meningitis.

3. *Infections in which there is no Satisfactory Evidence of the Therapeutic Value of Chloramphenicol.*—Influenza, the common cold, poliomyelitis and encephalitis, tuberculosis, syphilis, ulcerative colitis.

Chloramphenicol is probably effective in a number of pyogenic infections, such as baeterial pneumonias, gonorrhoea, and peritonitis, but it is doubtful whether it is as effective as penicillin or sulphonamides. In bacterial endocarditis due to organisms which are penicillin-resistant, chloramphenicol is probably inferior to a combination of streptomycin and penicillin. An exception to this is bacterial endocarditis due to penicillin-resistant *Staph. pyogenes*; for this, as for any severe penicillin-resistant staphylococcal infection, "aureomycin" is the antibiotic of choice.

It should be noted that chloramphenicol in the powdered form has an extremely bitter taste. It is not, therefore, easily administered to young children who will not swallow capsules.

THE BLAIR-BELL MEDAL

PRESENTATION TO PROFESSOR MUNRO KERR

The first Blair-Bell medal of the Royal Society of Medicine, awarded quinquennially for the advancement of science in gynaecology or obstetrics or both in the preceding five years, was presented to Professor J. M. Munro Kerr in the presence of a distinguished company on November 30. The medal was designed by Mr. Carter Preston.

Lord Webb-Johnson, President of the Royal Society of Medicine, said that he had not known Blair-Bell as well as he would have liked, but he well knew his brother, who wore himself to death in the service of the wounded in the first world war. It was a delight to see many members of Blair-Bell's family present on this occasion. The medal was a beautiful example of the engraver's art. On one side it bore an excellent portrait of Blair-Bell, and on the other a design to represent Juno Lucina, the chief goddess of childbirth. He spoke of his great admiration and affection for the first recipient of the award.

Mr. V. B. Green-Armytage, President of the Section of Obstetrics and Gynaecology of the Royal Society of Medicine, and Professor Hilda Lloyd, President of the Royal College of Obstetricians and Gynaecologists, then presented Professor Munro Kerr to Lord Webb-Johnson. In doing so, Mr. Green-Armytage said that for over 50 years Professor Munro Kerr had adorned and embellished their profession; during that time he had stimulated countless students—undergraduate and postgraduate—and had earned the regard and affection of countless colleagues. When it was learned that Professor William Blair-Bell had left £500 to the Royal Society of Medicine to establish a medal to be given every five years to the man or woman who had done most to advance science in gynaecology and obstetrics it was the unanimous vote of their Section of the Society that the first recipient should be their guest of that evening.

Professor Munro Kerr, after receiving the medal at the hands of Lord Webb-Johnson, said how deeply he was touched and how greatly he prized the honour. When he heard that this honour had been given him he wondered what some of his old colleagues now in the Elysian fields would say about it. Probably they would say that it was only what was to be expected in the case of a Scot, long-lived and persistent.

He appreciated the medal the more because it had been handed to him by a great surgeon. The relationship between surgeons and gynaecologists had not always been so friendly and amicable as it was to-day. When he looked back to the 'eighties, at the time when he was a student, he recalled that gynaecologists were recruited from old obstetricians who had very little experience of abdominal surgery. They had one